Guidance on Person-Centered Planning

Related to Affordable Care Act, Section 2402(a)

November 24, 2014

What is Section 2402(a)?

- Part of the Patient Protection and Affordable Care Act (ACA)
- Section 2402(a) is "Oversight and Assessment of the Administration of Home and Community-Based Services"
- It requires HHS regulations "to ensure states develop community-based long-term services and supports (LTSS) systems designed to allocate resources and provide the necessary supports and coordination ***to be responsive to the person-centered needs and choices of older adults and people with disabilities in ways that maximize their independence and ability to engage in self-direction of their services***, and achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs."

Guidance on Section 2402(a)

- HHS released guidance on Section 2402(a) on June 6, 2014.
- This is a summary of that guidance.

Primary Tenets of Person-Centered Planning

Person-Centered Planning:

- is directed by the person with LTSS needs
- includes freely chosen representatives
- identifies strengths, goals, preferences, needs, desired outcomes
- includes the person's goals and preferences, needs and desires
- assists the person to construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments
- highlights individual responsibility including appropriate risks
- helps the team working with the individual get to him/her better

The role of the agency is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during planning.

Person-Centered Planning (PCP) Process

PCP is implemented in a manner that:

1. supports the person
2. makes him or her central to the process
3. recognizes the person as the expert on goals and needs

Person-Centered Planning Process

In the PCP process:

1. the person or representative has ***control over who is included*** in the planning process
2. ***is timely and occurs at times and locations of convenience to the person***, his/her representative, family members, and others.
3. ***necessary information and support is provided*** to ensure the person and/or representative is central to the process and understands the information
4. ***uses a strengths-based approach to identify the positive attributes of the person***, including an assessment of the person's strengths and needs
5. ***Uses personal preferences to develop goals***, and to meet the person's HCBS needs

Person-Centered Planning Process

In the PCP process:

6. the person's ***cultural preferences must be acknowledged***
7. ***meaningful access is provided to participants and/or their representatives with limited English proficiency***
8. people under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, ***have the opportunity to address any concerns***
9. includes ***mechanisms for solving conflict or disagreement*** within the process, including clear conflict of interest guidelines
10. information is ***offered on the full range of HCBS available*** to support achievement of personally identified goals

Person-Centered Planning Process

In the PCP process:

11. the person or representative ***is central in determining*** what available HCBS are appropriate and will be used
12. the ***person able to choose between providers or provider entities,*** when choice is available
13. the PCP ***is reviewed at least every twelve months or sooner***, when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request
14. the PCP ***is not constrained by any pre-conceived limits on the person's ability to make choices***
15. ***Employment and housing in integrated settings must be explored,*** and planning is consistent with the individual's goals and preferences, including where she or he resides, and who they live with

Elements of the Person-Centered Plan

The person-centered service plan must identify the services and supports that are necessary to meet the person's identified needs, preferences, and quality of life goals. It must include the following elements.

1. ***Reflect that the setting where the person resides is chosen by the individual, which must be integrated and support full access*** to the greater community
2. ***Must be understandable*** by the person and/or representative
3. ***Must consider and document positive attributes*** of the person
4. ***Must identify risks***, while considering the person's right to assume some degree of risk, and ***include measures available to reduce risks or find alternate ways to achieve personal goals***
5. ***Goals must be documented in the person's and/or representative's own words***, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person; ***goals consider the quality of life concepts important to the person***

Elements of the Person-Centered Plan

6. Must describe the services and supports that will be necessary and specify services to be provided through various resources including natural supports
7. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented
8. ***The plan must assure the health and safety of the person***
9. Non-paid supports and items needed to achieve the goals must be documented
10. The plan must include the signatures of everyone with responsibility for its implementation and a timeline for review. ***The plan should be discussed with family/friends/ caregivers designated by the individual so that they fully understand it and their role(s)***

Elements of the Person-Centered Plan

11. ***Any effort to restrict the right of a person to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented***
12. The plan must identify the person(s) and/or entity responsible for monitoring its implementation
13. The plan must identify needed services, and prevent unnecessary or inappropriate services and supports
14. ***An emergency back-up plan must be documented that encompasses a range of circumstances***
15. The plan must address elements of self-direction if a self-directed service delivery system is chosen
16. All persons directly involved in the planning process must receive a copy of the plan or portion of the plan

Person-Centered Planning Implementation

Successful implementation requires:

- Monitoring progress
- Ensuring that all HCBS - paid and unpaid - are delivered
- Ensuring that the plan is reviewed according to the established timeline;
- Ensuring that there is a feedback mechanism for the person or representative to report on progress, issues and problems
- Ensuring that changes can be made in an expedient manner.

Successful implementation requires that staff involved in the PCP process have a consistent understanding of the process and implementation.

Person-Centered Planning Implementation

For people using HCBS, this includes active engagement in the planning and service delivery process by:

- Providing accurate information for eligibility and service planning.
- Actively identifying and engaging providers, case managers, family members, friends, direct support workers, support brokers, medical professionals, and others.
- Approving and signing only a plan that is developed and accepted by everyone involved.
- Participating fully after the approved plan is implemented (e.g., appearing timely for meetings and appointments, reviewing the plan regularly).
- Providing regular feedback on the HCBS provided.
- Being fully involved in the process to update their service plans based on their needs and preferences on an ongoing and regular basis, no less often than annually